Patient Financial Information

The following information is required to update our files. This information will be entered into our computer system and a Face Sheet will be generated for your signature to certify that the information given is true and complete.

Client Name:_____

Birthdate:_____ **Soc. Sec. #**_____

Current Address:_____

Mailing Address:_____

Home Phone Number:_____

Work Phone Number:_____

Alternate Contact Number:_____

You will be charged a fee for our services based on your family size and annual income. Please provide the following information to assist in determining your fee. You may request a review of the fee charge. You have the right to refuse to give financial information, thereby accepting a fee equal to the full cost of service.

Do you have Medicaid, Medicare, or Private Insurance? Yes_____No_____
If yes please provide a copy of your insurance card.

INCOME FOR YOUR COMPLETE HOUSEHOLD OR FAMILY UNIT
List each family member in household and include ALL types of income.

NAME	DATE OF BIRTH	FAMILY RELATION	PLACE OF EMPLOY-MENT OR OTHER SOURCE OF INCOME	INCOME BEFORE TAXES OR DEDUCT.
1				$ WK BW MO
2				$ WK BW MO
3				$ WK BW MO
4				$ WK BW MO
5				$ WK BW MO
6				$ WK BW MO
7				$ WK BW MO
8				$ WK BW MO

Do you pay out Child Support? Yes_____ No_____ How much monthly?_____

Do you pay out Child Care? Yes_____ No_____ How much monthly?_____

Florida HEALTH